SPECIAL REPORT

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July 30, 1996 No. 96-4

BOSTON MEDICAL CENTER

The Right Choice But The Real Work Is Just Beginning

On July 1, 1996, the Boston Medical Center (BMC) was established following the approval of the merger agreement between Boston City Hospital (BCH) and Boston University Medical Center Hospital (BUMCH) by the City Council on June 28, 1996. For the first time in this country, a public and a private hospital of approximately equal strengths joined to create a private hospital with a public mission. This agreement created a new health care system in Boston involving BMC, the Public Health Commission and HealthNet, an affiliation of ten neighborhood health centers. The BMC, consisting of BCH, Boston Specialty and Rehabilitation Hospital and BUMCH is a private, nonprofit hospital that will retain BCH's designation as a public service hospital and maintain its mission of providing health care services to all. Boston is experiencing the start of a significant health market restructuring which involves the growth of managed care. In this situation, the City had three objective in pursuing the merger: 1) preserve the mission, 2) minimize the negative impact on jobs and 3) limit the City's financial obligations. After an intensive six week independent evaluation of the merger agreement, the Bureau concluded that the merger proposal is the best of the proposed options to fulfill the City's objectives over the long term. The merger also puts BMC in a stronger position to meet the market objectives of competitive cost, successful referral network and agile management.

While the merger is clearly the best option, its success is not assured. The real work is just beginning and will require extraordinary management skill with the ability to act quickly and decisively. The ability of BMC to be cost competitive is critical to its success as is its ability to build strong referral relations with HealthNet and to expand its patient base. The City cannot and should not guarantee the success of BMC through greater financial support than envisioned in the merger agreement. The City must respect its new relationship with BMC and allow management to make the required operating and strategic decisions without interference. In return, the Public Health Commission should hold BMC accountable for clear service and financial goals that focus on patient outcomes and performance. The various constituencies who supported the merger and want the mission continued should stand ready to support the tough choices that will have to be made in order for BMC to succeed.

Check List For BMC's Success

- ✓ Establish strong referral relationships and joint managed care contracting with primary care providers to maintain or expand patient base and obtain sufficient share of the growing managed care market segment.
- ✓ Transform the institution's image among consumers by providing quality health care with the greatest attentiveness to patients' needs and desires at all levels.
- ✓ Achieve an appropriate cost structure to establish financial viability at cost levels similar to, if not lower than, competitors. Significant reduction of labor costs through staff reductions and improved productivity will be critical.
- ✓ Implement fundamental and innovative redesign of health care delivery and related business practices.
- ✓ Attract and foster exceptionally skilled management that is able to react quickly and decisively to market opportunities and competitor actions.

This report is based on the Bureau's full report, *The Future of Boston City Hospital: Analysis of Proposal To Merge BCH and University Hospital,* which was released on June 20, 1996. To assist in preparing an informed assessment of the full merger proposal and assumptions, the Bureau assembled a team of management, finance, health care and legal experts. This team consisted of individuals from the public accounting firm of Deloitte & Touche LLP, the management consulting firm of McKinsey & Company, Inc. and the Research Bureau. A review of legal documents implementing various aspects of the proposed merger was undertaken by the law firm of Ropes & Gray. The full report is available upon request

Managed Care Will Restructure Boston Market

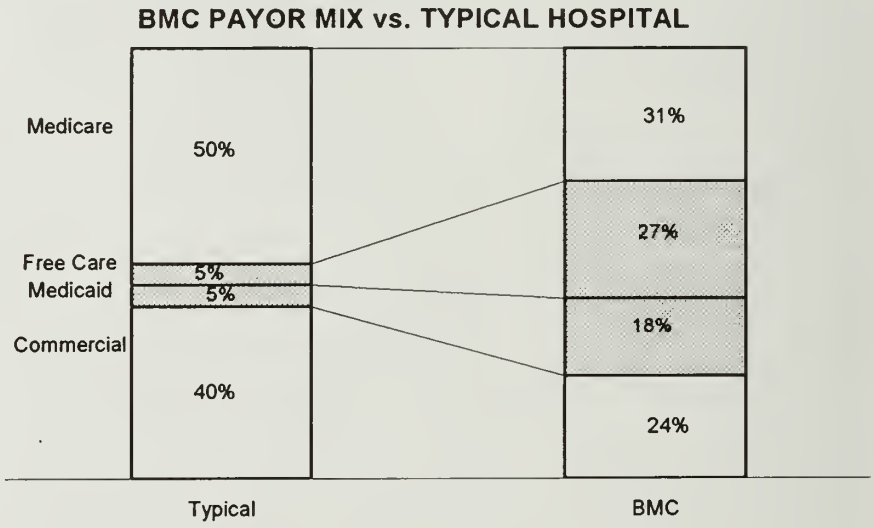
Boston is at the beginning of a market restructuring that is certain to reduce the number of beds and will likely force some hospitals to close. Today's Boston has higher capacity, utilization and costs when compared to national averages and other mature markets. At the same time, Boston is also among the most highly penetrated HMO markets in the country and thus is at the forefront of "managed care." Managed care will inexorably reshape the Boston market as it has already in other markets by reducing reimbursement rates, changing provider incentives and decreasing inpatient utilization.

The influence of managed care is already evident in the 5% per year decline of Massachusetts hospital utilization from 1990 to 1994. The decline in inpatient services has also occurred at BCH - the average patient days per month at BCH declined from 6,600 patient days for 1995 to 5,660 as of YTD May 1996, a 14% decrease. Pressure is being exerted on health plans to lower premiums by Boston employers through the Massachusetts Healthcare Purchasers Group. These and other efforts have resulted in a decline in the percentage rate change for health care premiums from 9% in 1992 to 3% in 1993 to 0% in 1994 and a decrease of 1% in 1995 and an estimated decrease in premiums of 2% in 1996. These steps along with changes in the rate and method of payment for government programs will continue to accelerate the pace of restructuring in the Boston health care market.

The likely evolution of the Boston market can be seen in the experience of Minneapolis, which from 1985 to 1994 through the merger of hospitals into integrated systems, closed 8 of its 28 hospitals. In Boston, the formation of these integrated systems is well under way with plans for three major health care systems: Massachusetts General/Brigham and Women's (Partners), Beth Israel/Pathway and Lahey-Hitchcock.

Despite Its Mission, BMC Will Not Be Immune To Market Changes

The merger established an improved payer mix for BMC but one still more reliant on government programs than on commercial business which drove the dramatic restructuring in Minneapolis. Nevertheless, BMC will not be immune to these pressures. BMC receives 45% of its revenues from Medicaid and the Free Care Pool in contrast to the typical hospital that receives only 10% from these programs with the remainder from commercial payers and Medicare.



Government programs are undergoing significant change that mirrors the cost reduction efforts in the commercial market. These changes include a movement to managed care, shift to risk-based arrangements with providers and a reduction in overall reimbursement. In Massachusetts, the Commonwealth is aggressively applying managed care to the Medicaid program, opening up the market to competition. As this occurs, reimbursement and usage decisions will move from government decision-makers to HMOs, Primary Care Physicians and/or case managers. These purchasers will be concerned about cost, quality and service and will be unwilling to pay a premium to BMC for its unique mission and cost structure.

The Free Care Pool is under pressure to restructure as a result of a growth in expenses of nearly 10% annually from 1993 to 1995 resulting in increased funding shortfalls and escalating financial pressures on hospitals. Long-term reform efforts are likely to result in programs which enroll the uninsured into either Medicaid or other managed care plans. This would make primary care and preventative health services available to the uninsured. As a result, the utilization of hospital services by this population is likely to decline and competition for patient referrals is likely to increase. Medicare, also, is increasingly migrating to managed care plans. The shift of government programs to managed care will inevitably result in lost revenue for BMC as reimbursement levels fall, competition increases and patients are directed to the lowest-cost hospitals.

Boston Medical Center Is The Right Choice

The Boston Medical Center represents the best opportunity to meet the market objectives of competitive cost, successful referral network and agile management. That is the conclusion reached by the Bureau which evaluated four options for BCH in the context of which would be able to overcome the cost, market share and agility obstacles to compete successfully and also balance the City's objectives of mission, jobs and cost. The four options were: (1) Status Quo, (2) Independent Authority, (3) Merger and (4) Shutdown. With fewer structural impediments, BMC is in a better position to enhance management agility and make the cost reductions necessary to be more competitive. In a public structure, management is constrained by civil service rules, collective bargaining work provisions and union negotiations conducted in a political process. Public purchasing requirements are cumbersome and make it difficult to join purchasing cooperatives or negotiate unique business terms resulting in reduced prices. Multiple reviews of management's operating decisions including additional oversight by the Mayor, City Council and the general public inhibit effective and timely action. The new structure will also facilitate BMC's ability to improve its image and service levels and make it more attractive to a broader patient population, including managed care patients. Also, network building could be more easily coordinated. The Bureau's analysis concluded that the status quo and independent authority options were not viable over the long term. Indeed, the Bureau suggested that if the merger was not approved, the option to shutdown BCH should be considered.

Financial Comparison Favors BMC - The Bureau's assessment found that the merger was expensive but financially manageable and that it did establish boundaries around future financial exposure for the City. This merger comes at a critical time for the City, just prior to a period of significant change in the health care market that would require far greater city resources to pursue the independent authority or status quo options. While the City's financial commitments to the merger are high, most are funded by available resources associated with the Department of Health and Hospitals (DHH). As a result of these merger obligations, the City will record a loss of $16.0 million in its General Fund undesignated fund balance as of June 30, 1996. The City's General Fund undesignated fund balance at the start of fiscal 1996 was $89.6 million.

In five years, BMC should be in a more positive financial position and require significantly less support from the City than the other two options. Based on forecasted financial statements compiled by the public accounting firm of Coopers & Lybrand LLP, BMC should end fiscal 2001 with net income of $2.6 million. That contrasts with an operating loss of $42.1 million for the independent authority and a loss of $47.7 million for BCH as a city department. Over the five years, the City's contribution to the BMC would be $68.0 million as compared to a subsidy of $152.9 million for the independent authority and $169.1 million for the status quo. Incurring these added costs would affect the City's ability to provide for other basic city services such as public safety and education. In the current fiscal 1997 budget, the Departments of School, Police and Fire account for 54.4% of the total departmental budget but 67.3% of the total annual increase.

FIVE YEAR SUMMARY
($ in Millions)

	BCH Status Quo	Independent Authority	BMC
Net Income/(Loss) by 2001	($47.7)	($42.1)	$2.6
Grants/Contribution/Subsidy from Boston	$169.1	$152.9	$68.0
$ Cost Over BMC	$101.1	$84.9	-----

Source: Coopers & Lybrand LLP, Report dated June 28, 1996

In addition to the annual operating expenses, the City has agreed to additional financial obligations which are significant and will be paid over a short period of time. These expenses will total approximately $63.9 million and represent a transfer of funds, existing liabilities that must be paid sooner than expected and one-time expenses. These costs will be funded by available revenues associated with DHH operations and will not require a commitment of new resources from the City.

Challenges Ahead For BMC - Recommendations

While the merger is clearly the best option, its success is not guaranteed and will require exceptionally skilled management to steer BMC through the tough challenges ahead. A number of critical market uncertainties remain including the future of federal and state health funding, the rate of change in hospital utilization and managed care penetration and how aggressively other hospitals in Boston will compete for patients in BMC's market area. BMC must strive to be cost competitive while providing high quality services, maintain patient market share, create a supportive culture and act quickly and decisively as the market evolves. Failure to meet these objectives will mean that BMC's long-term survival will be much less assured. In light of the market uncertainties and the need for BMC to be competitive, the Bureau makes the following recommendations:

✓ BMC must achieve competitive low costs in order to succeed. In general, the teaching hospitals have established cost saving goals of 20-25% to achieve competitiveness. Savings at this level cannot be realized without reducing labor costs and will be more difficult for BMC because of its high capital obligations. Management must strive to meet or exceed its cost targets through personnel actions including reengineering, expense reduction and increases in productivity.

BMC's cost targets over the next five years indicates the difficult challenge before it. Bed size of the hospital is expected to decline from a total of 630 to between 350 and 400 beds. Total staff in FTE's are planned to be reduced by 1,210 positions or 29%. Reductions in staffing will occur at a more rapid pace than accompanying declines in volume and must start before the beginning of the new fiscal year on October 1, 1996. Salary and wage increases are projected to increase by less than general inflation. Collective bargaining contracts are expected to be negotiated in a way that is cost competitive and allows for flexibility and innovation. BMC may be able to realize greater savings from the merger by moving into a single facility as soon as actionable.

✓ BMC must build strong referral relations with HealthNet and primary care payers to maintain and perhaps expand the system's patient base. Improving the strength of the relationship developed between BMC and HealthNet is critical to its survival. Today, the current HealthNet affiliation with BMC is not particularly strong. Currently, no more than 25-40% of HealthNet patients are admitted to BMC, the remainder being admitted to other local hospitals. At the same time, HealthNet members are being actively courted by hospitals/systems with much greater financial capacity. In addition, the growth of managed care will require BMC to increase its penetration into managed care referral networks by establishing strong referral relations and alliances with community-based primary care providers. Presently, only 17% of BMC's patient base is covered through managed care. Medicare and Medicaid, excluding HMOs, represent 44% of BMC's patient base and Free Care Pool and self-pay plans represent 27%. As these programs convert to managed care, BMC must secure contracts with the managed care providers to retain its patient share.

✓ BMC must provide patient satisfaction through the delivery of quality services in a working environment in which the cultures of the two institutions work harmoniously in support of a single mission. Staffing, attitude and services should appear seamless with no distinctions in either facility. Management and employees need to be mutually supportive in this unique partnership. Any acrimony from merger discussions or contract negotiations that carries over to the hospital floors will affect the satisfaction of patients, all of whom now have access to other hospitals if they choose.

✓ BMC must undertake a fundamental and innovative redesign of its health care delivery and related business practices. To succeed competitively, BMC must establish clarity of its managerial and operational structure and a complete understanding of the roles and responsibilities of all aspects of its operation.

✓ BMC must be able to respond quickly to competitor actions and market opportunities. As providers compete for fewer patients, competition will increase. Survival critically depends on management being adaptable and creative in identifying and seizing opportunities including additional mergers or alliances, or even innovative approaches to restructuring costs and responding to threats.

✓ The City cannot and should not guarantee the success of BMC through greater financial support than envisioned in the merger agreement. Indeed, no amount of city funding can guarantee the success of BMC. The City must respect its new relationship with BMC and allow management to make the required operating and strategic decisions without interference. City Hall must accept a "hands off" policy. Public oversight should be focused on the achievement of objectives rather than on day-to-day management decisions. In return, the City, through the Public Health Commission, should hold BMC accountable to clear standards that focus on patient outcomes, quality of care, access and cost effectiveness. Future city appropriations should be based on BMC's ability to provide services that support the mission.

✓ The governance body of BMC must provide the requisite leadership to assist management going forward. The Trustees just appointed must utilize their collective expertise to provide leadership and be able to rise above parochial interests and serve the best interests of BMC.

✓ All the various constituencies, including the business community, who supported the merger and want the mission continued should stand ready to support the tough choices that will have to be made in order for BMC to succeed.